Differentiation of Suicidal Behaviour

a practical clinical approach

REMCO DE WINTER
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Parnassia Groep

VU UNIVERSITY AMSTERDAM
No Conflict of Interest
• When recognition severe suicidal behaviour >
Mental health

Mental health: best expertise suicidal behaviour??

- Assessment and taxation in mental health!
- Guide
- treatment
- Saving lives
Suicidal behaviour leading to death

- Mostly no involvement of MH?
  - Netherlands <40%
  - World <30%

- When dead too late for MH....

- Selection of suicidal behaviour
## Suicide in mental Health

- (Dutch) All population: \( \approx 11/100.000 \)
- MH population: \( \approx 80-90/100.000 \)
- General population: \( \approx 6-7/100.000 \) (exclusive MH)

17% improvement in MH gives < 6.8 decrease all
Suicide and the MH worker

- Giant impact
- Experience > who?
  - responsibility
  - Blaming
  - Burn-out
  - Lawsuits
  - ......
  - Better treatment
  - zero
Suicidal behaviour

- Symptom? Pathological behaviour? Reaction on extreme event?
- Only 2 classifications less suicidal behaviour
Uniformity definitions?

- No differentiation suicidal behaviour (entrapment)
Society has high expectations

- **Treatment**
  - Our range of treatment (and possibilities)!

But also

- **In media?**
  - Do nothing
  - Are not serious
  - Too fast discharge

- **Lawsuits**
  - Court “blaming”
Better differentiation

- Als better tailored treatment
  - Psychotherapy
  - medication
  - Treatment in general
  - Guidance outside mental health care
- More consensus about responsibilities
- Less defensive medicine
Guidelines

- Non description of differentiation of SB
- Suicidal behaviour uniform?

- Evidence for medication?
  - Clozapine
  - Lithium
(Psycho)therapy
Rare research on heterogeneity/differentiation suicidal behavior!

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>PubMed Search results 320 all, reviews 85</td>
<td>PubMed Search results 644 all, reviews 236</td>
</tr>
<tr>
<td>all</td>
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<td>reviews</td>
<td>review</td>
</tr>
<tr>
<td>0</td>
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</tbody>
</table>

- Lopez-Castroman e.a. 2016 1) Impulsive ambivalent, 2) well planned, 3) frequent attempts
- Ginley & Bagge 2017 1) Major depressive disorder, 2) High internalizing, 3) high externalizing
- Wołodzko & Kozoszka (polish review) 1) comorbid mental disorders, 2) without mental disorders or mild symptoms, 3) personality disorders externalizing, 4) avoiding contacts, socially withdrawn 5) depressive
Differentiation suicidal behaviour

- Based on practice and theory
  - Dimensions of psychopathology
    - Psychotic: perceptual disintegration (behavioural disintegration)
    - Depression: emotional dysregulation
  - Dimensions of personality (temperament and character)
    - impulsivity (novelty seeking, harm avoidance)
    - Cognitive coping (self directedness, cooperativeness)
### The Model

<table>
<thead>
<tr>
<th>Primary Depressive Cognition</th>
<th>Perceptual Disintegration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depression</td>
<td>Psychotic (depression)</td>
</tr>
<tr>
<td>Stress sensitivity↑↑</td>
<td>lose sense of reality</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychosocial Entrapment</th>
<th>Inadequate Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious loss experience</td>
<td>Conditioning/coping</td>
</tr>
<tr>
<td>Short-lived depressive thoughts</td>
<td>Psychological pain</td>
</tr>
<tr>
<td></td>
<td>Entrapment counselors</td>
</tr>
</tbody>
</table>
Suicidal behavior:
- Arises from disturbed perception/psychosis or influenced by a large extent
- Psychosis has a direct relation to the suicidal behavior
- Is mainly explained by psychosis.

- With a and b it is taken into account that psychosis can be explained by various causes. For example, if a person with a serious loss experience becomes psychotic and suicidal, and psychosis has a direct relation with suicidal behavior.

This can also appear during psychosis and suicidal behavior after substance (ab)use.
Primary Depressive Cognition **PDC**

### Suicidal behavior:
- Mainly from depression or primary depressive thoughts are the most important etiology;
- Has a relationship with longer existing depressive thought or seems directly related to gloom, or the cognition of serious failure;
- There is no relationship with any psychotic symptomatology and suicidal behavior or a sudden reactive depression.
Psychosocial Entrapment PE

- **Suicidal behavior:**
  - Very reactive and situation-bound, a direct reaction to serious loss experience and/or serious injury and experience of completely cramped;
  
  - Mainly explained by seriously experienced loss experience, injury or real impending doom (can exist with long-standing depressive symptoms < two weeks and no psychosis;
  
  - Is not used as a means of communication about suffering.
Suicidal behavior:
- does not arise from a depressive or psychotic disorder
- arises mainly from another underlying suffering than described in other types
- is expressed to emphasize pressure of suffering and/or to get something done from someone else. This coping strategy can be seen as an expression of the inability to communicate needs, wishes and desires in a different, more constructive way.
- is connected with the expectation that the response to suicidal behavior can offer a direct solution. Avoid the term `manipulation`
Primary Depressive Cognition ↔ Perceptual Disintegration
- Depression (cognition)
- Stress/vulnerability
- Long duration?

Psychosocial Entrapment ↔ Inadequate Communication
- Experiencing serious loss
- Reactive depressive thoughts
- Short duration?

"Rumination"

MH/society ↔ Mental Health/society

- Psychotic/nihilistic
- Reality testing
- Short duration?

MH/society ↔ Mental Health/society
- Inadequate coping
- Psychological pain
- Entrapment counsellors
- Medium duration on chronic?
Modifiers in model

- Substance abuse modifier for all
- Organic/somatic explanations
Questionnaire

1) Perceptual Disintegration (disintegration perception & hallucinations)

Score: 0 = not present.
1 = Psychosis has relevance to suicidal behavior, but most of behavior can be explained by something else.
2 = Largely explained by psychosis.

2) Primary Depressive Cognition

Score: 0 = not present.
1 = Societal behavior has a relationship with long-standing depressive cognition or appears as a result of low mood, failure or poor performance, however there is some doubt.
2 = Mostly explained by depressive cognition, not related to psychosis. There is no evidence of a relationship with psychotic symptomatology and suicidality or a suicidal event.

3) Psychosocial Entrapment

Score: 0 = not present.
1 = Suicidal behavior appears to have a direct reactive relationship to recent events. There may be other explanations for emergence of suicidal behavior.
2 = Mostly explained by event perceived as loss, humiliation, or imminent threat. There may be depression symptoms however they have existed less than 2 weeks and without abnormal thought content. Suicidal behavior is not used as a way to communicate distress.

4) Inappropriate Coping (communication)

Score: 0 = not present.
1 = Behavior is suspect of being used to cope with suffering and/or for related reasons. Suicidal behavior can be perceived as being used to manipulate. Manipulation is used because there is no other coping strategy to communicate distress in a different and more constructive way.
2 = There is an obvious relationship between behavior of suicidal ideation and the immediate, reactive, and expected response. A depressive or psychotic disorder has been excluded.

<table>
<thead>
<tr>
<th>subtype</th>
<th>notes</th>
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<tr>
<td>Overt denial</td>
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<td>Primary Depressive Cognition</td>
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<td>Overdetermined</td>
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<tr>
<td>Inappropriate Coping (communication)</td>
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Validation model

- 100 conclusions outreaching emergency psychiatry
- 4 psychiatrists

“Preliminary” concordance
- **Perceptual Disintegration (PD)**,
- **Primary Depressive Cognition (PDC)**
- **Psychosocial Entrapment (PE)**
- **Inadequate Communication & Coping (IC)**
Inventarisation emergency psychiatry MH

- Building database
  - N = 498

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<tr>
<th>differentiatie</th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
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<td>13,3</td>
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<tr>
<td>Total</td>
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Psycho-social contributing factors and suicidal behaviour of patients who committed suicide between March 2016 and March 2017
Adult mental health services

April 2018

Sussex Partnership
NHS Foundation Trust
Post its

• Better differentiation better tailor made treatment?
• Better risk taxation?
• Better delineation of responsibilities?
• Borders of treatment of MH
• Responsibility society/community
- info@suicidaliteit.nl
- www.suicidaliteit.nl
- r.dewinter@parnassia.nl